CHIROPRACTIC SERVICES

MONTANA MEDICAID PROVIDER MANUAL

FEBRUARY 2000

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CHIROPRACTIC SERVICES

A. GENERAL OVERVIEW

Chiropractic services are generally rendered by providers enrolled with Montana Medicaid and are billed through Consultec, the Department's fiscal intermediary. **Chiropractic services payable by Montana Medicaid are limited to those provided to 1) children age 20 and under (also referred to as EPSDT) and 2) Qualified Medicare Beneficiaries.**

Please note: Medicaid does not reimburse for any chiropractic services provided to individuals age 21 and over who are eligible for Medicaid without also qualifying for QMB.

This Manual is to be used in conjunction with other appropriate Montana Medicaid Provider Manuals, Administrative Rules of Montana, the Department's Fee Schedule and your yellow Montana Medicaid Provider Handbook. The Manuals and the Handbook are available from Consultec. Consultec Provider Relations may be reached at 406-442-1837 (Helena and out-of-state) and 800-624-3958 (in-state toll-free).

B. DEFINITIONS

- **Chiropractic services** means the manipulation of the spine by a licensed chiropractor in accordance with the laws of the state in which he or she is practicing.

- **Qualified Medicare Beneficiary** – In 1988, Congress established the Qualified Medicare Beneficiary (QMB) program. Through QMB, Medicaid pays the Medicare premiums, coinsurance, and deductibles for eligible Medicare recipients. (Please refer to Section G for more detail.)

  There are two eligibility classifications of Qualified Medicare Beneficiaries – QMB only eligible or QMB/Medicaid eligible. For more information about QMB, please refer to Section X of your yellow Montana Medicaid Provider Handbook.

C. PROVIDER ENROLLMENT

State licensed chiropractors who wish to bill Montana Medicaid for services provided to Qualified Medicare Beneficiaries must be enrolled as a QMB provider. A separate provider number is needed for state licensed chiropractors to bill for services provided to children age 20 and under.

D. BENEFITS AND LIMITATIONS

- Payment for chiropractic services provided to individuals age 20 and under is limited to evaluation and management office visits, manual manipulation of the spine and x-rays to support diagnosis of subluxation of the spine.

- Payment for chiropractic services provided to Qualified Medicare Beneficiaries is limited to manual manipulation of the spine to correct a subluxation. The Montana Medicaid program will pay only the Medicare coinsurance and deductibles for Qualified Medicare Beneficiaries who receive chiropractic services. (Please refer to Section G for more details.)

- The Department maintains the right to review claims for medical necessity.

E. MEDICAID ELIGIBILITY

PROVIDERS ARE REQUIRED TO CONFIRM 1) MEDICAID ELIGIBILITY FOR INDIVIDUALS AGE 20 AND UNDER AND 2) QMB ELIGIBILITY FOR ALL OTHER PATIENTS FOR THE DATE OF SERVICE. For more information about Medicaid and QMB Identification cards, please refer to Section IV, Medicaid Eligibility, of your yellow Montana Medicaid Provider Handbook.

For enrolled providers, Montana Medicaid offers five additional methods to confirm eligibility.

1. **AVRS** - Automated Voice Response System: The AVRS can verify eligibility for specific dates of service. Limited TPL information and any other restrictions will also be given. The AVRS can be reached at (800) 714-0060.

2. **FAXBACK** - FAXBACK can also verify eligibility. To sign up for FAXBACK please contact the Consultec Provider Relations Unit. FAXBACK can be reached at (800) 714-0075.

3. The **Public Access System** is accessed using a PC and modem. Medicaid providers may subscribe to the Public Access System by contacting:

   Operations and Technology Division
   Department of Public Health and Human Services
   P.O. Box 4210
   Helena, MT 59604
   (406) 444-1752

   The cost of subscribing to the Public Access System is $100.00 every six- (6) months. Once connected, providers can dial in 24 hours a day, 7 days a week to verify Medicaid eligibility information for recipients.

4. **Medicaid Eligibility and Payment System (MEPS)** – Montana Medicaid providers can now access recipient eligibility through the Internet. The MEPS system is available via the 'Medicaid' kiosk in the DPHHS room of the Montana Virtual Human Services Pavilion: http://vhsp.dphhs.state.mt.us. To access MEPS, you must first receive a password from DPHHS. This can be done by printing the MEPS Access Request Form from the MEPS site and mailing it to DPHHS. In a few days the MEPS Security Officer will contact you to verify your request and to give you your new MEPS password. You will be required to change your password the first time you log on to MEPS.

5. **Provider Relations at Consultec** – Staff in Provider Relations will also respond to eligibility inquiries. If there are other issues including eligibility, Provider Relations staff would be the most appropriate contact. Please call 800-624-3958 (in-state toll-free) or 406-442-1837 (Helena and out-of-state providers).

FAXBACK and AVRS do not check program benefit limits. Telephone verification of eligibility cannot be relied upon as absolute proof of eligibility

F. BILLING PROCEDURES

- Use the HCFA-1500 billing form. Valid ICD-9-CM diagnosis codes are required for billing. See also the billing instructions in the Montana Medicaid Provider Handbook and your pink Completing the HCFA-1500 Form manual for further information on Medicaid requirements.

- **Claims for QMB (Medicare Part B insurance)** services must be submitted to the Medicare Part B insurance carrier for Medicare payment and then submitted to Consultec on the appropriate claim form with the EOMB attached. The Part B carrier may, under an agreement with the Department, submit the claims by electronic media to Medicaid. See also Section VI, Item H of the Montana Medicaid Provider Handbook for more information about Medicaid/Medicare crossover claims.

  Note: To ensure your Medicare Part B claims crossover on the electronic transmission from Medicare, contact the Provider Relations staff at Consultec.

- When you bill for children age 20 and under or your claims do not automatically crossover on the electronic transmission from Medicare, send your claims (with EOB's attached if the patient is a QMB recipient) to:

  Consultec
  P.O. Box 8000
  Helena, MT 59604

- HCFA-1500 claim forms may be obtained from most office supply stores and print shops that carry office forms. They are not provided by the Department or by Consultec. Any questions about billing procedures for Montana Medicaid claims should be directed to the Provider Relations Department at Consultec at 406-442-1837 (Helena and out-of-state providers) or 800-624-3958 (in-state toll-free).

- For recipients with a PASSPORT designation on the Medicaid ID card, chiropractors must obtain a prior authorization from the recipient's PASSPORT provider.

- If there is a PASSPORT provider and you have obtained the proper authorization, enter the PASSPORT provider's identification number in box 17a on the HCFA-1500 for payment.

- Usual and customary charges are those charges that the provider would normally charge for a service, regardless of payment methodology. Providers cannot bill Medicaid an amount more than they would charge other patients. Also, you must bill Medicaid for the same charges as you billed to Medicare.

  All charges for services submitted to Medicaid must be made in accordance with an individual provider's USUAL AND CUSTOMARY charges to the general public unless:

  1. A provider has entered into an agreement with the Department to provide services at a negotiated rate, or

  2. A provider has been directed by the Department to submit charges at a Department specified rate.

G. REIMBURSEMENT

- For chiropractic services for children age 20 and under, the Department shall pay the lowest of:
  - The provider's actual (submitted) charge for the service or
  - The Department's fee schedule as specified in the Resource Based Relative Value Scale (RBRVS) reimbursement.

- For patients who are eligible for Medicare and QMB (or Medicare, QMB and Medicaid), Medicaid will reimburse the lower of the Medicare coinsurance and deductible or the Medicaid fee less the amount paid by Medicare for the same service.

H. PROCEDURE CODES

Use the following procedure codes to bill Medicaid for services provided to individuals age 20 or under:

CODE	DESCRIPTION
99201 through 99205	Office or other outpatient services -New Patient
99211 through 99215	Office or other outpatient services - Established Patient
98940 through 98943	Chiropractic Manipulative Treatment
72010	Radiological examination, spine, entire, survey study, anteroposterior and lateral
72040	Radiological examination, spine, cervical; anteroposterior and lateral
72070	Radiological examination, spine, thoracic; anteroposterior and lateral
72100	Radiological examination, spine, lumbosacral; anteroposterior and lateral

Use the following procedure codes to bill Medicaid for services provided to Qualified Medicare Beneficiaries:

CODE	DESCRIPTION
98940 through 98943	Chiropractic Manipulative Treatment

I. CO-PAYMENT

The Medicaid program requires co-payment participation of Medicaid recipients age 21 and older. This includes adults who are QMB only or QMB/Medicaid eligible. The co-payment for chiropractic services is $1.00 per service. Do not deny services if the recipient does not have the co-payment amount at the time of service. You may bill the recipient for co-payments owed.

Pregnant woman, persons age 20 and under, and persons in a nursing home are exempt from co-payment. Please refer to your yellow Montana Medicaid Provider Handbook, Section III, Provider Requirements, for more information about co-payments.